



Greater Hartford Legal Aid, Inc.

Testimony of Jamey Bell Greater Hartford Legal Aid

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SB 1: AAC Increasing Access to Affordable, Quality Health Care **January 31, 2007**

Thank you Sen. Handley, Rep. Sayers, and the Public Health Committee for this opportunity to testify about Proposed Senate Bill 1, **AAC Increasing Access to Affordable, Quality Health Care**. I have worked as a legal aid lawyer for almost 25 years, and have represented low-income health care consumers, primarily children, for the last 13 years. I enthusiastically support the concept and underlying purpose of Senate Bill 1, since I believe that access to health care is a basic human right and the responsibility of a just and ethical community.

My testimony makes three main points:

- 1) Access to oral health care must be an integral part of any comprehensive health care plan;***
- 2) A comprehensive plan to provide affordable, quality health care should not perpetuate existing systems that purport to serve large numbers of vulnerable CT residents, but are actually broken;***
- 3) A new system must learn from the lessons of existing broken programs and impose sustainability and accountability.***

1) Access to oral health care must be an integral part of any comprehensive health care plan. It was evident before but can no longer be questioned that oral health is integral to overall health. Dental care is not an optional health service, cosmetic, or a second-tier health care need. This was confirmed by Attorney General David Satcher's 2000 report which called the mouth "a mirror for general health and well-being. ... To ignore oral health problems can lead to needless pain and suffering, complications that can devastate well-being, and financial and social costs that significantly diminish quality of life and burden American society." The report highlights recent research findings that point to associations between chronic oral infections and diabetes, heart and lung disease, stroke and low-birth-weight premature births.

Lack of dental care for children is even more unconscionable in that it represents a fundamental failure to protect our community's most vulnerable members. Lack of care can lead to extensive dental disease, hospitalization for acute infections, increased risk of disease in permanent teeth, serious pain and poor nutrition. Tooth decay is 5 times more common than asthma and 7 times more common than hay fever in children. Oral health problems are responsible for more missed school days than any other type of health problem. Thousands of CT's children have dental problems severe enough that they wake up with a toothache, or fail to



fall asleep because of one. And the fact that these outcomes are all *completely preventable* compounds the tragedy.

Given that oral health conditions systemically affect the entire body, integrating oral health promotion and oral health care access into a comprehensive health care plan is essential. There will be no true “comprehensive health” in the plan without it.

2) A comprehensive plan to provide affordable, quality health care should not perpetuate existing systems that purport to serve large numbers of vulnerable CT residents, but are actually broken. To the extent this new plan is built or expands upon existing health care programs for low-income residents, the new plan must ensure essential health care access—CARE, not just a CARD—to families, while allowing the state to ensure it receives *value* for its money.

My participation in a lawsuit against the state for its failures to engage enough dental providers in the Medicaid managed care (HUSKY A) program, has informed my perspective on the effectiveness of CT's existing Medicaid system. According to the Department of Social Services' (DSS) reports to the federal government, for the past 15 years, less than 30% of Connecticut's children on Medicaid (HUSKY A and fee-for-service) have seen a dentist even once a year, though the American Academy of Pediatrics recommends children get check-ups and cleanings every six months. Access to Medicaid dental providers-- both in the safety net (community, school-based and hospital clinics) as well as private practice-- is limited in large part because rates paid under the Medicaid program are often too low to even cover the provider's overhead costs.

DSS itself has now documented that “**access to care is apparently deficient across all MCOs and provider groups**” in results of a “Secret Shopper” survey conducted by Mercer Governmental Human Services Consulting in 2006. Researchers, posing as new HUSKY A patients, attempted to obtain appointments with pediatricians, dentists, dermatologists, neurologists and orthopedic surgeons. Only 33.5 % of all calls to pediatricians resulted in scheduled appointments. Worse, only 27% of calls to dentists resulted in appointments. Success in obtaining appointments for the other health care providers was equally poor or worse: for dermatologists, 30%; neurologists, 15.8%; orthopedic surgeons, 17%. Broken down by MCO, the best performing MCO's pediatrician appointment success rate was 40%, while the worst was 26%. The best MCO performer for dentist appointment availability scored at 30%; the worst was 19%.

A simple comparative dramatically illustrates the disparity between Medicaid rates and rates sufficient to attract an adequate dental provider network. For the state of Connecticut employee health plan, the state pays about \$22.50 per member per month for oral health care. By contrast, DSS allocates about \$8.00 per member per month (of its managed care capitation payment) toward dental care. The state of Connecticut is legally responsible for both programs but spends nearly 3 times as much per covered life in the state employee program. Not surprisingly, the disparity between dental care *utilization* rates between these two groups reflects this severe funding disparity. State employees and their families utilize dental care services at a rate of

75%. As noted above, DSS regularly reports that fewer than 30% of kids on Medicaid receive dental care in any given year.

3) A new system must learn from the lessons of existing broken programs and impose sustainability and accountability. Preventive oral health care, which is the cheapest type of oral health care by far, reduces the disease burden and saves money. Low income children who have their first preventive visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally related costs are almost 40% lower over a five year period than children who receive their first preventive visit after age one. Without access to regular preventive dental services, dental care for many children is postponed until symptoms, such as toothache and facial abscess, become so acute that care is sought in hospital emergency departments. A three-year aggregate comparison of Medicaid reimbursement for inpatient emergency department treatment (\$6,498) versus preventive treatment (\$660) revealed that on average, the cost to manage symptoms related to dental caries on an inpatient basis is approximately 10 times more than to provide dental care for these same patients in a dental office.

A comprehensive plan to provide affordable, quality health care should therefore provide dental and medical homes for consumers, with an emphasis on real access to cost-effective preventive care and treatment, not just a "plan on paper". In addition to eliminating access barriers described above, a "universal" plan should avoid other broken features of the existing Medicaid managed care model such as burdensome administrative processes that deter provider participation and eat into funding for services, and the "at-risk" insurance model that builds in a financial incentive to deny care in order to maximize profit. Finally, the existing Medicaid managed care system exhibits a woeful lack of transparency (how is the state's money spent?), performance measures (how do we know if the program is working?), accountability (can the state fix problems in the system?) and sustainability (is there an effective way of keeping up with necessary costs?), and should not be replicated.

Thank you for your attention.